NIH OCCUPATIONAL MEDICAL SERVICE
DOCUMENTATION OF IMMUNIZATIONS- SUMMER 2016

Name _____ SSN (Last 4) _____

Phone (Home and/or Cell) _____ Date of Birth _____

1. **Tuberculosis** *(a PPD test administered on or after **9/1/15 is required**)*
   PPD Placed
   _____Yes _____ No Date Placed: _____
   5 T.U. 0.1 ml ID _____ L _____ R forearm Mfg/Lot# _____
   Result
   Date: _____ _____ Negative _____ Positive: _____ mm
   or IGRA Blood test for TB
   Type: _____ Date: _____ Results: ____ Positive _____ Negative
   For Any Positive Results (TST/IGRA)
   Date of last chest x-ray _____
   (Must be within 2 years; attach copy of x-ray report)
   INH recommended _____Yes _____ No
   Duration of treatment _____

2. **Tetanus/Diphtheria**
   Date of last booster _____ *(Must be within 10 years)* Tdap _____ Td _____

3. **Measles (Rubeola)**
   Date of Immunizations *(2 doses required)* #1 _____ #2 _____
   OR Provide documentation of positive titer (attach)

4. **Chickenpox (Varicella)**
   Date of Immunizations *(2 doses required)* #1 _____ #2 _____
   OR Provide documentation of either positive titer or history of disease (attach)

5. **Hepatitis B**
   Date of Immunizations*(3 doses required)*
   #1 _____ #2 _____ #3 _____
   OR Provide documentation of positive titer (attach)

Healthcare Provider's Signature _____ **Date**_____

Printed Name _____
Provider's Address (or stamp)

_____

_____

Phone _____